



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

HUTCHINSON AREA HEALTH CENTER

**Respondent Name**

TEXAS MUTUAL INSURANCE COMPANY

**MFDR Tracking Number**

M4-14-0116-01

**Carrier's Austin Representative Box**

Box Number 54

**MFDR Date Received**

September 9, 2013

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "both facility claims were denied as non-emergent. We were informed on 04-15-13 by Kendra at Texas Mutual that we appeal their decision, however, they already had the records, and per Texas workers compensation law, non-emergent care is not covered. All patients who present to our emergency room are assessed according to their complaints. We do not deny treatment according to the patient's insurance or ability to pay."

**Amount in Dispute:** \$2,056.36

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "date stamp lists the received date as 9/9/13 on the requestor's DWC-60 packet, a date greater than one year from 8/12/12, 8/14/12, and 8/15/12. The requestor has waived its right to DWC MDR."

**Response Submitted by:** Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 12, 2012	Emergency Room Services	\$2,056.36	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
  - 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2
  - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
  - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION.

## Issue

1. Under what authority is the request for medical fee dispute resolution considered?
2. Did the requestor waive the right to medical fee dispute resolution?

## Findings

1. The requestor is a health care provider that rendered disputed services in the state of Minnesota to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.
2. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is August 12, 2012. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on September 9, 2013. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

## Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

## Authorized Signature

_____ Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	June 30, 2014 Date
--------------------	--	-----------------------

## ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**